I cannot but think that, with some people, asepsis is a thing that is regarded as excellent in theory, and to be practised with great zeal inside an operating theatre, pretty much as religion is sometimes reserved for the weekly church service; but it is really the asepsis of daily ward life that is important, and that is a matter of feeling, not of theory. The secret of success in dealing with infectious disease lies in knowing by instinct, firstly, when one's hands, instruments, and clothing are in the surgical sense dirty, and, secondly, how to clean them.

Let us, then, consider what are the more obvious sources of infection. Firstly, there is the dust of the ward. Into the atmosphere of the ward the patients it contains are constantly breathing or excreting all kinds of germs, which, at first hotter than the rest of the air, rise up, and *may* then—if the ventilation is exceptionally good—go out of the ward altogether, but more usually, when they become cold, sink down again, and lie, as *dust*, on the floors, bedclothes, and walls of the wards; from these situations they may be conveyed by hands, feeding-cups, or what not, to the patients, and re-infection may occur. Here the remedy is obvious: the dust must be removed, not by "dusting" (*i.e.*, simply turning it loose into the air again), but by sweeping it away with a wet rag or mop; dust is most easily dislodged by first turning it into mud.

Then there is the risk of infecting other patients in the course of treatment. For instance, it is necessary that the throats of most patients should be cleaned, and this is done by washing away with some mild antiseptic solution the germs that have grown and accumulated on the tonsils or are lying loose in the mouth. Now, supposing this washing is done with a Higginson's syringe, one end of which is in the patient's mouth and the other in the bowl of lotion, however perfectly the syringe is working—and syringes of this type seldom work properly for very long—some germs are bound to get back from the mouth into the tube of the instrument. The nurse now goes on to the next patient, changes the nozzle of the syringe, and proceeds as before, with the result that the germs from the previous patient are injected into the mouth of the second one, the not uncommon result being then called a "relapse" of the original throat condition! Even if the instrument be not to blame, the nurse's hands in the process of syringing may become infected with germs from the patient's mouth, though she may not be conscious of the fact, and in the handling of the next patient infection may occur as before. The remedy is again obvious. No syringe of any kind should be allowed inside a ward where infectious diseases are treated, but all irrigation, whether of throats or wounds, should be done with a douche-can, using a separate, recently-boiled nozzle for each patient, and the nurse should wash her hands before going from one patient to any other; it is perhaps also necessary to add that she should not wear sleeves while she is carrying out the treatment of throats. I have sometimes wondered incidentally what the average nurse would think of a surgeon who syringed out an abscess in one patient with a Higginson syringe, and then, merely changing the nozzle, went on to the next case that happened to have an abscess and repeated the procedure without first washing his hands. Once call it surgery, and the dirtiness of the method is obvious; the only difference is that the mouth happens to contain a larger assortment of germs, and those, too, often more virulent, than the average abscess.

The most important point in the nursing of infectious disease is, as I have said, to endeavour to feel, instinctively as it were, when the hands and instruments are surgically clean; when once that sense has been obtained the details of the methods of aseptic surgery follow with but a little reasoning. A good nurse, for instance, will feel directly her hands have touched anything that may contain germs, and will, as a matter of course, and almost unconsciously, remove the infective matter forthwith. She will also regard obvious dirt in cupboards, and on walls and floors, not merely as something that does not look nice, or that she would not like the authorities to see, but as an actual store of infection for her patients, which may be drawn upon at any time without her knowledge.

I have tried thus to briefly sketch a few of the more important points of fever nursing. At first, the routine of cleaning and scrubbing seems somewhat irksome, but it is only until the true importance of the necessity for absolute cleanliness becomes apparent. It is, after all, but a necessary preliminary to the attainment of that skill which reveals to the worker the intense fascination of a close fight with an acute disease for the life or working power of a strong adult, or of a child with all the possibilities of life before it.

A Loss to the Nursing World.

The announcement that Miss M. E. Shipley, Matron of the Fulham Infirmary, Hammersmith, has resigned her position, and is leaving London in September, will be received with great regret by all who know her and her work. Of a naturally retiring disposition, she has identified herself with progressive movements from a conscientious conviction that a trained nurse in these days only fulfils her duty in part if she does not share in the public work connected with her profession. She was trained at St. Thomas's Hospital, and, after twenty-three years of work, is compelled, by medical advice, to take a year's complete rest. We hope that the end of this time may find her restored in health.

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